LEGISLATURE OF THE STATE OF IDAHO

Sixtieth Legislature First Regular Session - 2009

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 108

BY BUSINESS COMMITTEE

AN ACT

RELATING TO INSURANCE; AMENDING SECTION 41-2103, IDAHO CODE, TO REVISE WHO SHALL BE PERMITTED TO REMAIN ON CERTAIN POLICIES AND TO MAKE TECHNICAL CORRECTIONS; AMENDING SECTIONS 41-2210, 41-3216 AND 41-3436, IDAHO CODE, TO REVISE WHO SHALL BE PERMITTED TO REMAIN ON CERTAIN CONTRACTS; AMENDING SECTION 41-3923, IDAHO CODE, TO PROVIDE THAT CERTAIN PERSONS BE PERMITTED TO REMAIN ON CERTAIN CONTRACTS; AMENDING SECTIONS 41-4023 AND 41-4124, IDAHO CODE, TO REVISE WHO SHALL BE PERMITTED TO REMAIN ON CERTAIN CONTRACTS; AMENDING SECTION 41-4703, IDAHO CODE, TO REVISE WHO SHALL BE PERMITTED TO REMAIN ON CERTAIN PLANS AND TO MAKE A TECHNICAL CORRECTION; AND AMENDING SECTIONS 41-5203 AND 41-5501, IDAHO CODE, TO REVISE WHO SHALL BE PERMITTED TO REMAIN ON CERTAIN PLANS.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Section 41-2103, Idaho Code, be, and the same is hereby amended to read as follows:

41-2103. SCOPE AND FORMAT OF POLICY. No policy of disability insurance shall be delivered or issued for delivery to any person in this state unless it otherwise complies with this code, and complies with the following:

(1) The entire money and other considerations therefor shall be expressed therein;

(2) The time when the insurance takes effect and terminates shall be expressed therein;

(3) It shall purport to insure only one (1) person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family, who shall be deemed the ~~policy holder~~ policyholder, any two (2) or more eligible members of that family, including husband, wife and any other dependent or dependents. As used in this subsection (3) and for all new and renewing policies, "dependent" includes an unmarried child ~~under the age of twenty one (21) years, an unmarried child who is a full time student~~ under the age of twenty-five (25) years and who ~~is financially dependent upon~~ receives more than one-half (1/2) of his financial support from the parent, ~~and~~ or an unmarried child of any age who is medically certified as disabled and dependent upon the parent;

(4) The style, arrangement and overall appearance of the policy shall give no undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers shall be plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten (10) point with a lower case unspaced alphabet length not less than one hundred ~~and~~ twenty (120) point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions);

(5) The exceptions and reductions of indemnity shall be set forth in the policy and, other than those contained in sections 41-2105 ~~to~~ through 41-2127, ~~inclusive, of this chapter~~ Idaho Code, shall be printed, at the insurer's option, either included with the benefit provisions to which they apply, or under an appropriate caption such as "exceptions," or "exceptions and reductions," except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies;

(6) Each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof;

(7) The policy shall contain no provision purporting to make any portion of the charter, rules, constitution or ~~by-laws~~ bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the director;

(8) When the policy provides payment for medical or surgical expense to the insured, on a reimbursement basis, or otherwise, the insured shall be entitled to a free choice of medical doctor to perform said services, or the free choice of a podiatrist if the latter is authorized by law to perform the particular medical or surgical services covered under the terms of said policy; and

(9) When the policy provides for payment for the expense of services that are within the lawful scope of practice of a duly licensed optometrist, on a reimbursement basis or otherwise, the insured shall be entitled to a free choice of medical doctor or optometrist to perform such services.

SECTION 2. That Section 41-2210, Idaho Code, be, and the same is hereby amended to read as follows:

41-2210. REQUIRED PROVISION IN GROUP AND BLANKET POLICIES. (1) Any group disability insurance contract or blanket disability insurance contract, delivered or issued for delivery in this state which provides coverage for injury or sickness for newborn dependent children of subscribers or other members of the covered group, shall provide coverage for such newborn children, including adopted newborn children that are placed with the adoptive subscriber or other member of the covered group within sixty (60) days of the adopted child's date of birth, from and after the moment of birth. Coverage under the contract for an adopted newborn child placed with the adoptive subscriber or other member of the covered group more than sixty (60) days after the birth of the adopted child shall be from and after the date the child is so placed. Coverage provided in accord with this section shall include, but not be limited to, coverage for congenital anomalies. For the purposes of this section, "child" means an individual who has not attained age eighteen (18) years as of the date of the adoption or placement for adoption. For the purposes of this section, "placed" shall mean physical placement in the care of the adoptive subscriber or other member of the covered group, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it shall mean when the adoptive subscriber or other member of the covered group signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child. Prior to legal finalization of adoption, the coverage required under the provisions of this subsection (1) as to a child placed for adoption with a subscriber or other member of the covered group continues in the same

manner as it would with respect to a naturally born child of the subscriber or other member of the covered group until the first to occur of the following events:

(a) Date the child is removed permanently from that placement and the legal obligation terminates; or

(b) The date the subscriber or other member of the covered group rescinds, in writing, the agreement of adoption or agreement assuming financial responsibility.

(2) An insurer shall not restrict coverage under a group disability insurance contract or a blanket disability insurance contract of any dependent child adopted by a participant or beneficiary, or placed with a participant or beneficiary for adoption, solely on the basis of a preexisting condition of a child at the time the child would otherwise become eligible for coverage under the plan, if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the plan.

(3) Any new or renewing group disability insurance contract or blanket disability insurance contract delivered or issued for delivery in this state shall provide that an unmarried child ~~under the age of twenty one (21) years or an unmarried child who is a full time student~~ under the age of twenty-five (25) years and who ~~is financially dependent upon~~ receives more than one-half (1/2) of his financial support from the parent shall be permitted to remain on the parent's or parents' contract. Further, any unmarried child of any age who is medically certified as disabled and financially dependent upon the parent is permitted to remain on the parent's or parents' contract.

(4) No policy of disability insurance which provides maternity benefits for a person covered continuously from conception shall be issued, amended, delivered, or renewed in this state on or after January 1, 1977, if it contains any exclusion, reduction, or other limitations as to coverage, deductibles, or coinsurance provisions, as to involuntary complications of pregnancy, unless such provisions apply generally to all benefits paid under the policy. If a fixed amount is specified in such policy for surgery, the fixed amounts for surgical procedures involving involuntary complications of pregnancy shall be commensurate with other fixed amounts payable for procedures of comparable difficulty and severity. In a case where a fixed amount is payable for maternity benefits, involuntary complications of pregnancy shall be deemed an illness and entitled to benefits otherwise provided by the policy. Where the policy contains a maternity deductible, the maternity deductible shall apply only to expenses resulting from normal delivery and cesarean section delivery; however, expenses for cesarean section delivery in excess of the deductible shall be treated as expenses for any other illness under the policy. This section shall apply to all disability policies except any group disability policy made subject to an applicable collective-bargaining agreement in effect before January 1, 1977.

For purposes of this section, involuntary complications of pregnancy shall include, but not be limited to, puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia.

All policies subject to this section and issued, amended, delivered, or renewed in this state on or after January 1, 1977, shall be construed to be in compliance with this section, and any provision in any such policy which is in conflict with this section shall be of no force or effect.

(5) From and after January 1, 1998, no policy of disability insurance which provides medical expense maternity benefits, shall restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child in a manner that would be in conflict with the newborns' and mothers' health protection act of 1996.

SECTION 3. That Section 41-3216, Idaho Code, be, and the same is hereby amended to read as follows:

41-3216. BENEFITS. (1) A society may provide the following contractual benefits in any form:

(a) Death benefits;

(b) Endowment benefits;

(c) Annuity benefits;

(d) Temporary or permanent disability benefits;

(e) Hospital, medical or nursing benefits; and

(f) Monument or tombstone benefits to the memory of deceased members; and

(g) Such other benefits as authorized for life insurers and which are not inconsistent with this chapter.

(2) A society shall specify in its rules those persons who may be issued, or covered by, the contractual benefits in subsection (1) of this section, consistent with providing benefits to members and their dependents. A society may provide benefits on the lives of children under the minimum age for adult membership upon application of an adult person.

(3) Any new or renewing society contract relating to hospital, medical or nursing benefits delivered or issued for delivery in this state shall provide that an unmarried child ~~under the age of twenty-one (21) years or an unmarried child who is a full-time student~~ under the age of twenty-five (25) years and who ~~is financially dependent upon~~ receives more than one-half (1/2) of his financial support from the parent shall be permitted to remain on the parent's or parents' contract. Further, any unmarried child of any age who is medically certified as disabled and financially dependent upon the parent is permitted to remain on the parent's or parents' contract.

SECTION 4. That Section 41-3436, Idaho Code, be, and the same is hereby amended to read as follows:

41-3436. DEPENDENT'S COVERAGE – DEPENDENT'S TERMINATION OF COVERAGE, DISABILITY AND DEPENDENCY PROOF AND APPLICATION. (1) Any new or renewing subscriber contract delivered or issued for delivery in this state shall provide that an unmarried child ~~under the age of twenty-one (21) years or an unmarried child who is a full-time student~~ under the age of twenty-five (25) years and who ~~is financially dependent upon~~ receives more than one-half (1/2) of his financial support from the parent shall be permitted to remain on the parent's or parents' contract. Further, any unmarried child of any age who is medically certified as disabled and financially dependent upon the parent is permitted to remain on the parent's or parents' contract.

(2) There shall be a provision that a subscriber's contract delivered or issued for delivery in this state more than one hundred twenty (120) days after the effective date of this act under which coverage of a dependent of a subscriber terminates at a specified age shall, with respect to an unmarried child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapable prior to attainment of the limiting age and who is chiefly dependent upon such member for support and maintenance, not to terminate while the contract remains in force and the dependent remains in such condition, if the member has within thirty-one (31) days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity as described herein. The service corporation

may require at reasonable intervals during the two (2) years following the child's attainment of the limiting age subsequent proof of the child's disability and dependency. After the two (2) year period, such subsequent proof may not be required more than once each year.

SECTION 5. That Section 41-3923, Idaho Code, be, and the same is hereby amended to read as follows:

41-3923. COVERAGE OF ADOPTED NEWBORN CHILDREN – COVERAGE OF MATERNITY AND COMPLICATIONS OF PREGNANCY. (1) Any contract delivered or issued for delivery in this state by an organization offering a managed care plan for which a certificate of authority is required, which provides coverage for injury or sickness for newborn dependent children of the members of the covered group, shall provide such coverage for such newborn children and infants, including adopted newborn children that are placed with the adoptive member of the covered group within sixty (60) days of the adopted child's date of birth, from and after the moment of birth. Coverage under the contract for an adopted newborn child placed with the adoptive member of the covered group more than sixty (60) days after the birth of the adopted child shall be from and after the date the child is so placed. Coverage provided in accord with this section shall include, but not be limited to, coverage for congenital anomalies. For the purposes of this section, "child" means an individual who has not reached eighteen (18) years as of the date of the adoption or placement for adoption. For the purposes of this section, "placed" shall mean physical placement in the care of the adoptive member of the covered group, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it shall mean when the adoptive member of the covered group signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child. Prior to legal finalization of adoption, the coverage required under the provisions of this subsection (1) as to a child placed for adoption with a member of the covered group continues in the same manner as it would with respect to a naturally born child of the member of the covered group until the first to occur of the following events:

(a) Date the child is removed permanently from that placement and the legal obligation terminates; or

(b) The date the member of the covered group rescinds, in writing, the agreement of adoption or agreement assuming financial responsibility.

(2) The managed care organization shall not restrict coverage under a health care contract of any dependent child adopted by a member, or placed with a member for adoption, solely on the basis of a preexisting condition of the child at the time the child would otherwise become eligible for coverage under the plan, if the adoption or placement for adoption occurs while the member is eligible for coverage under the plan.

(3) Any new or renewing group disability insurance contract or blanket disability insurance contract delivered or issued for delivery in this state shall provide that an unmarried child under the age of twenty-five (25) years and who receives more than one-half (1/2) of his financial support from the parent shall be permitted to remain on the parent's or parents' contract. Further, any unmarried child of any age who is medically certified as disabled and financially dependent upon the parent is permitted to remain on the parent's or parents' contract.

(4) No health care contract which provides maternity benefits for a person covered continuously from conception shall be issued, amended, delivered, or renewed in this state if it

contains any exclusion, reduction, or other limitations as to coverage, deductibles, copayments, or coinsurance provisions as to involuntary complications of pregnancy, unless such provisions apply generally to all benefits paid under the plan. If a fixed amount is specified in such plan for surgery, the fixed amounts for surgical procedures involving involuntary complications of pregnancy shall be commensurate with other fixed amounts payable for procedures of comparable difficulty and severity. In a case where a fixed amount is payable for maternity benefits, involuntary complications of pregnancy shall be deemed an illness and entitled to benefits otherwise provided by the plan. Where the plan contains a maternity deductible, the maternity deductible shall apply only to expenses resulting from normal delivery and cesarean section delivery; however, expenses for cesarean section delivery in excess of the deductible shall be treated as expenses for any other illness under the plan.

Where a plan which provides or arranges direct health care services for its members contains a maternity deductible, the maternity deductible shall apply only to expenses resulting from prenatal care and delivery. However, expenses resulting from any delivery in excess of the deductible amount shall be treated as expenses for any other illness under the plan. If the pregnancy is interrupted, the maternity deductible charged for prenatal care and delivery shall be based on the value of the medical services received, providing that it is never more than two-thirds (2/3) of the plan's maternity deductible.

This section shall apply to all health care contracts except any group health care contracts made subject to an applicable collective-bargaining agreement in effect before January 1, 1977.

For purposes of this section, involuntary complications of pregnancy shall include, but not be limited to, puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia.

All health care contracts subject to this section and issued, amended, delivered, or renewed in this state on or after January 1, 1977, shall be construed to be in compliance with this section, and any provision in any such plan which is in conflict with this section shall be of no force or effect.

(~~4~~5) From and after January 1, 1998, no policy of disability insurance which provides medical expense maternity benefits shall restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child in a manner that would be in conflict with the newborns' and mothers' health protection act of 1996.

SECTION 6. That Section 41-4023, Idaho Code, be, and the same is hereby amended to read as follows:

41-4023. COVERAGE FROM MOMENT OF BIRTH – COMPLICATIONS OF PREGNANCY. (1) Every self-funded plan issued in this state or providing coverage to any covered family residing within this state, shall contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn child or infant of any covered family covered, including a newborn child placed with the adoptive covered family within sixty (60) days of the adopted child's date of birth. Coverage under the self-funded plan for an adopted newborn child placed with the adoptive covered family more than sixty (60) days after the birth of the adopted child shall be from and after the date the child is so placed. Coverage provided in accordance with this section shall include, but not be limited to, coverage for congenital anomalies. For the purposes of this section, "child" means an individual who has not reached eighteen (18) years of age as of the date of the adoption or placement for adoption. For the purposes of this section, "placed" shall mean physical placement in the care

of the adoptive covered family, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it shall mean when the adoptive covered family signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child. Prior to legal finalization of adoption, the coverage required under the provisions of this subsection (1) as to a child placed for adoption with a covered family continues in the same manner as it would with respect to a naturally born child of the covered family until the first to occur of the following events:

(a) Date the child is removed permanently from that placement and the legal obligation terminates; or

(b) The date the covered family rescinds, in writing, the agreement of adoption or agreement assuming financial responsibility. No such plan may be issued or amended if it contains any disclaimer, waiver, or other limitation of coverage relative to the coverage or insurability of newborn or adopted children or infants of a covered family covered from and after the moment of birth that is inconsistent with the provisions of this section.

(2) Neither the plan trustee or employer nor an insurer shall restrict coverage under a self-funded plan of any dependent child adopted by a participant or beneficiary, or placed with a participant or beneficiary for adoption, solely on the basis of a preexisting condition of the child at the time the child would otherwise become eligible for coverage under the plan, if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the plan.

(3) No self-funded plan which provides maternity benefits for a person covered continuously from conception shall be issued, amended, delivered, or renewed in this state on or after January 1, 1977, if it contains any exclusion, reduction, or other limitations as to coverage, deductibles, or coinsurance provisions as to involuntary complications of pregnancy, unless such provisions apply generally to all benefits paid under the plan. If a fixed amount is specified in such plan for surgery, the fixed amounts for surgical procedures involving involuntary complications of pregnancy shall be commensurate with other fixed amounts payable for procedures of comparable difficulty and severity. In a case where a fixed amount is payable for maternity benefits, involuntary complications of pregnancy shall be deemed an illness and entitled to benefits otherwise provided by the plan. Where the plan contains a maternity deductible, the maternity deductible shall apply only to expenses resulting from normal delivery and cesarean section delivery; however, expenses for cesarean section delivery in excess of the deductible shall be treated as expenses for any other illness under the plan. This subsection shall apply to all self-funded plans except any such plan made subject to an applicable collective-bargaining agreement in effect before January 1, 1977.

For purposes of this subsection, involuntary complications of pregnancy shall include, but not be limited to, puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia.

All plans subject to this subsection and issued, amended, delivered, or renewed in this state on or after January 1, 1977, shall be construed to be in compliance with this section, and any provision in any such plan which is in conflict with this section shall be of no force or effect.

(4) From and after January 1, 1998, no self-funded plan that provides maternity benefits shall restrict benefits for any hospital length of stay in connection with childbirth for the mother

or newborn child in a manner that would be in conflict with the newborns' and mothers' health protection act of 1996.

(5) Any new or renewing self-funded group disability plan or blanket disability plan delivered or issued for delivery in this state shall provide that an unmarried child ~~under the age of twenty-one (21) years or an unmarried child who is a full-time student~~ under the age of twenty-five (25) years and who ~~is financially dependent upon~~ receives more than one-half (1/2) of his financial support from the parent shall be permitted to remain on the parent's or parents' plan. Further, any unmarried child of any age who is medically certified as disabled and financially dependent upon the parent is permitted to remain on the parent's or parents' plan.

SECTION 7. That Section 41-4124, Idaho Code, be, and the same is hereby amended to read as follows:

41-4124. SERVICES PROVIDED BY GOVERNMENTAL ENTITIES. (1) From and after July 1, 2006, no joint public agency self-funded plan shall be issued in Idaho which excludes from coverage services rendered the subscriber while a resident in an Idaho state institution, provided the services to the subscriber would be covered by the contract if rendered to him outside an Idaho state institution.

(2) From and after July 1, 2006, no joint public agency self-funded plan may contain any provision denying or reducing benefits otherwise provided under the policy for the reason that the person insured is receiving health or mental health care or developmental services provided by the department of health and welfare, whether or not the department of health and welfare bases its charges for such services on the recipient's ability to pay. Provided, nothing in this section shall prevent the issuance of a contract which excludes or reduces benefits where the charge level or amount of the charge levied by a governmental entity for such services would vary or be affected in any way by the existence of coverage under a joint public agency self-funded plan.

(3) Any new or renewing joint public agency self-funded plan delivered or issued for delivery in this state shall provide that an unmarried child ~~under the age of twenty-one (21) years or an unmarried child who is a full-time student~~ under the age of twenty-five (25) years and who ~~is financially dependent upon~~ receives more than one-half (1/2) of his financial support from the parent shall be permitted to remain on the parent's or parents' plan. Further, any unmarried child of any age who is medically certified as disabled and financially dependent upon the parent is permitted to remain on the parent's or parents' plan.

SECTION 8. That Section 41-4703, Idaho Code, be, and the same is hereby amended to read as follows:

41-4703. DEFINITIONS. As used in this chapter:

(1) "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the director that a small employer carrier is in compliance with the provisions of section 41-4706, Idaho Code, based upon the person's examination and including a review of the appropriate records and the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one (1) or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

(3) "Agent" means a producer as defined in section 41-1003(8), Idaho Code.

(4) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(5) "Board" means the board of directors of the small employer reinsurance program and the individual high risk reinsurance pool as provided for in section 41-5502, Idaho Code.

(6) "Carrier" means any entity that provides, or is authorized to provide, health insurance in this state. For the purposes of this chapter, carrier includes an insurance company, a hospital or professional service corporation, a fraternal benefit society, a health maintenance organization, any entity providing health insurance coverage or benefits to residents of this state as certificate holders under a group policy issued or delivered outside of this state, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

(7) "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that claim experience, health status and duration of coverage shall not be case characteristics for the purposes of this chapter.

(8) "Catastrophic health benefit plan" means a higher limit health benefit plan developed pursuant to section 41-4712, Idaho Code.

(9) "Class of business" means all or a separate grouping of small employers established pursuant to section 41-4705, Idaho Code.

(10) "Control" shall be defined in the same manner as in section 41-3801(2), Idaho Code.

(11) "Dependent" in any new or renewing plan means a spouse, an unmarried child ~~under the age of twenty-one (21) years, an unmarried child who is a full-time student~~ under the age of twenty-five (25) years and who ~~is financially dependent upon~~ receives more than one-half (1/2) of his financial support from the parent, ~~and~~ or an unmarried child of any age who is medically certified as disabled and dependent upon the parent.

(12) "Director" means the director of the department of insurance of the state of Idaho.

(13) "Eligible employee" means an employee who works on a full-time basis and has a normal work week of thirty (30) or more hours or, by agreement between the employer and the carrier, an employee who works between twenty (20) and thirty (30) hours per week. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a part-time, temporary, seasonal or substitute basis. The term eligible employee may include public officers and public employees without regard to the number of hours worked when designated by a small employer.

(14) "Established geographic service area" means a geographic area, as approved by the director and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

(15) "Health benefit plan" means any hospital or medical policy or certificate, any subscriber contract provided by a hospital or professional service corporation, or managed care

organization subscriber contract. Health benefit plan does not include policies or certificates of insurance for specific disease, hospital confinement indemnity, accident-only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance, student health benefits only coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance or nonrenewable short-term coverage issues for a period of twelve (12) months or less.

(16) "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(17) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least thirty (30) days. However, an eligible employee or dependent shall not be considered a late enrollee if:

(a) The individual meets each of the following:

(i) The individual was covered under qualifying previous coverage at the time of the initial enrollment;

(ii) The individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, or the involuntary termination of the qualifying previous coverage; and

(iii) The individual requests enrollment within thirty (30) days after termination of the qualifying previous coverage.

(b) The individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.

(c) A court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty (30) days after issuance of the court order.

(d) The individual first becomes eligible.

(e) If an individual seeks to enroll a dependent during the first sixty (60) days of eligibility, the coverage of the dependent shall become effective:

(i) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) In the case of a dependent's birth, as of the date of such birth; or

(iii) In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(18) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered or which could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(19) "Plan of operation" means the plan of operation of the program established pursuant to section 41-4711, Idaho Code.

(20) "Plan year" means the year that is designated as the plan year in the plan document of a group health benefit plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year ~~plan~~ is:

(a) The deductible/limit year used under the plan;

(b) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;

(c) If the plan does not impose deductibles or limits on a yearly basis or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year; or

(d) In any other case, the plan year is the calendar year.

(21) "Premium" means all moneys paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

(22) "Program" means the Idaho small employer reinsurance program created in section 41-4711, Idaho Code.

(23) "Qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under:

(a) Medicare or medicaid, civilian health and medical program for uniformed services (CHAMPUS), the Indian health service program, a state health benefit risk pool or any other similar publicly sponsored program; or

(b) Any other group or individual health insurance policy or health benefit arrangement whether or not subject to the state insurance laws, including coverage provided by a health maintenance organization, hospital or professional service corporation, or a fraternal benefit society, that provides benefits similar to or exceeding benefits provided under the basic health benefit plan.

(24) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

(25) "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to section 41-4711, Idaho Code.

(26) "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier to provide health care services to covered individuals.

(27) "Risk-assuming carrier" means a small employer carrier whose application is approved by the director pursuant to section 41-4710, Idaho Code.

(28) "Small employer" means any person, firm, corporation, partnership or association that is actively engaged in business that employed an average of at least two (2) but no more than fifty (50) eligible employees on business days during the preceding calendar year and that employs at least two (2) but no more than fifty (50) eligible employees on the first day of the plan year, the majority of whom were and are employed within this state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one (1) employer.

(29) "Small employer basic health benefit plan" means a lower cost health benefit plan developed pursuant to section 41-4712, Idaho Code.

(30) "Small employer carrier" means a carrier that offers health benefit plans covering eligible employees of one (1) or more small employers in this state.

(31) "Small employer catastrophic health benefit plan" means a higher limit health benefit plan developed pursuant to section 41-4712, Idaho Code.

(32) "Small employer standard health benefit plan" means a health benefit plan developed pursuant to section 41-4712, Idaho Code.

SECTION 9. That Section 41-5203, Idaho Code, be, and the same is hereby amended to read as follows:

41-5203. DEFINITIONS. As used in this chapter:

(1) "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the director that an individual carrier is in compliance with the provisions of section 41-5206, Idaho Code, based upon the person's examination and including a review of the appropriate records and the actuarial assumptions and methods used by the individual carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one (1) or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

(3) "Agent" means a producer as defined in section 41-1003(8), Idaho Code.

(4) "Base premium rate" means, as to a rating period, the lowest premium rate charged or that could have been charged under a rating system by the individual carrier to individuals with similar case characteristics for health benefit plans with the same or similar coverage.

(5) "Carrier" means any entity that provides health insurance in this state. For purposes of this chapter, carrier includes an insurance company, a hospital or professional service corporation, a fraternal benefit society, a health maintenance organization, any entity providing health insurance coverage or benefits to residents of this state as certificate holders under a group policy issued or delivered outside of this state, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

(6) "Case characteristics" means demographic or other objective characteristics of an individual that are considered by the individual carrier in the determination of premium rates for the individual, provided that claim experience, health status and duration of coverage shall not be case characteristics for the purposes of this chapter.

(7) "Control" shall be defined in the same manner as in section 41-3801(2), Idaho Code.

(8) "Dependent" in any new or renewing plan means a spouse, an unmarried child ~~under the age of twenty-one (21) years, an unmarried child who is a full-time student~~ under the age of twenty-five (25) years and who ~~is financially dependent upon~~ receives more than one-half (1/2) of his financial support from the parent, ~~and~~ or an unmarried child of any age who is medically certified as disabled and dependent upon the parent.

(9) "Director" means the director of the department of insurance of the state of Idaho.

(10) "Eligible individual" means an Idaho resident individual or dependent of an Idaho resident:

(a) Who is under the age of sixty-five (65) years, is not eligible for coverage under a group health plan, part A or part B of title XVIII of the social security act (medicare), or a state plan under title XIX (medicaid) or any successor program, and who does not have other health insurance coverage; or

(b) Who is a federally eligible individual (one who meets the eligibility criteria set forth in the federal health insurance portability and accountability act of 1996 Public Law 104-191, Sec. 2741(b) (HIPAA)).

An "eligible individual" can be the dependent of an eligible employee, which eligible employee is receiving health insurance benefits subject to the regulation of title 41, Idaho Code.

(11) "Established geographic service area" means a geographic area, as approved by the director and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

(12) "Health benefit plan" means any hospital or medical policy or certificate, any subscriber contract provided by a hospital or professional service corporation, or health maintenance organization subscriber contract. Health benefit plan does not include policies or certificates of insurance for specific disease, hospital confinement indemnity, accident-only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance, student health benefits only, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance, or nonrenewable short-term coverage issued for a period of twelve (12) months or less.

(13) "Index rate" means, as to a rating period for individuals with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(14) "Individual basic health benefit plan" means a lower cost health benefit plan developed pursuant to chapter 55, title 41, Idaho Code.

(15) "Individual catastrophic A health benefit plan" means a higher limit health benefit plan developed pursuant to chapter 55, title 41, Idaho Code.

(16) "Individual catastrophic B health benefit plan" means a health benefit plan with limits higher than an individual catastrophic A health benefit plan developed pursuant to chapter 55, title 41, Idaho Code.

(17) "Individual HSA compatible health benefit plan" means a health savings account compatible health benefit plan developed pursuant to section 41-5511, Idaho Code.

(18) "Individual standard health benefit plan" means a health benefit plan developed pursuant to chapter 55, title 41, Idaho Code.

(19) "New business premium rate" means, as to a rating period, the lowest premium rate charged or offered or which could have been charged or offered by the individual carrier to individuals with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(20) "Premium" means all moneys paid by an individual and eligible dependents as a condition of receiving coverage from a carrier, including any fees or other contributions associated with the health benefit plan.

(21) "Qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under:

(a) Medicare or medicaid, civilian health and medical program for uniformed services (CHAMPUS), the Indian health service program, a state health benefit risk pool, or any other similar publicly sponsored program; or

(b) Any group or individual health insurance policy or health benefit arrangement whether or not subject to the state insurance laws, including coverage provided by a managed care organization, hospital or professional service corporation, or a fraternal benefit society, that provides benefits similar to or exceeding benefits provided under the basic health benefit plan.

(22) "Rating period" means the calendar period for which premium rates established by a carrier are assumed to be in effect.

(23) "Reinsuring carrier" means a carrier participating in the Idaho individual high risk reinsurance pool established in chapter 55, title 41, Idaho Code.

(24) "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier to provide health care services to covered individuals.

(25) "Risk-assuming carrier" means a carrier whose application is approved by the director pursuant to section 41-5210, Idaho Code.

(26) "Individual carrier" means a carrier that offers health benefit plans covering eligible individuals and their dependents.

SECTION 10. That Section 41-5501, Idaho Code, be, and the same is hereby amended to read as follows:

41-5501. DEFINITIONS. As used in this chapter:

(1) "Agent" means a producer as defined in section 41-1003(8), Idaho Code.

(2) "Board" means the board of directors of the Idaho high risk individual reinsurance pool established in this chapter and the Idaho small employer reinsurance program established in section 41-4711, Idaho Code.

(3) "Carrier" means any entity that provides, or is authorized to provide, health insurance in this state. For purposes of this chapter, carrier includes an insurance company, any other entity providing reinsurance including excess or stop loss coverage, a hospital or professional service corporation, a fraternal benefit society, a managed care organization, any entity providing health insurance coverage or benefits to residents of this state as certificate holders under a group policy issued or delivered outside of this state, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

(4) "Dependent" in any new or renewing plan means a spouse, an unmarried child ~~under the age of twenty-one (21) years, an unmarried child who is a full-time student~~ under the age of twenty-five (25) years and who ~~is financially dependent upon~~ receives more than one-half (1/2) of his financial support from the parent, ~~and~~ or an unmarried child of any age who is medically certified as disabled and dependent upon the parent.

(5) "Director" means the director of the department of insurance of the state of Idaho.

(6) "Eligible individual" means:

(a) An Idaho resident individual or dependent of an Idaho resident who is under the age of sixty-five (65) years, is not eligible for coverage under a group health plan, part A or part B of title XVIII of the social security act (medicare), or a state plan under title XIX (medicaid) or any successor program, and who does not have other health insurance coverage; or

(b) An individual who is legally domiciled in Idaho on the date of application to the pool and is eligible for the credit for health insurance costs under section 35 of the Internal Revenue Code of 1986; or

(c) An Idaho resident individual or a dependent of an Idaho resident who is a federally eligible individual (one who meets the eligibility criteria set forth in the federal health insurance portability and accountability act of 1996 Public Law 104-191, Sec. 2741(b) (HIPAA)).

Coverage under a basic, standard, catastrophic A, catastrophic B, or HSA compatible health benefit plan shall not be available to any individual who is covered under other health insurance coverage, except as provided in section 41-5510(4), Idaho Code. For purposes of this chapter, to be eligible, an individual must also meet the requirements of section 41-5510, Idaho Code.

(7) "Health benefit plan" means any hospital or medical policy or certificate, any subscriber contract provided by a hospital or professional service corporation, or health maintenance organization subscriber contract. Health benefit plan does not include policies or certificates of insurance for specific disease, hospital confinement indemnity, accident-only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance, student health benefits only, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance, or nonrenewable short-term coverage issued for a period of twelve (12) months or less.

(8) "Individual basic health benefit plan" means a lower cost health benefit plan developed pursuant to section 41-5511, Idaho Code.

(9) "Individual carrier" means a carrier that offers health benefit plans covering eligible individuals and their dependents.

(10) "Individual catastrophic A health benefit plan" means a higher limit health benefit plan developed pursuant to section 41-5511, Idaho Code.

(11) "Individual catastrophic B health benefit plan" means a health benefit plan offering limits higher than a catastrophic A health benefit plan developed pursuant to section 41-5511, Idaho Code.

(12) "Individual HSA compatible health benefit plan" means a health savings account compatible health benefit plan developed pursuant to section 41-5511, Idaho Code.

(13) "Individual standard health benefit plan" means a health benefit plan developed pursuant to section 41-5511, Idaho Code.

(14) "Plan" or "pool plan" means the individual basic, standard, catastrophic A, catastrophic B, or HSA compatible health benefit plan established pursuant to section 41-5511, Idaho Code.

(15) "Plan of operation" means the plan of operation of the individual high risk reinsurance pool established pursuant to this chapter.

(16) "Pool" means the Idaho high risk reinsurance pool.

(17) "Premium" means all moneys paid by an individual and eligible dependents as a condition of receiving coverage from a carrier, including any fees or other contributions associated with the health benefit plan.

(18) "Qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under:

(a) Medicare or medicaid, civilian health and medical program for uniformed services (CHAMPUS), the Indian health service program, a state health benefit risk pool, or any other similar publicly sponsored program; or

(b) Any group or individual health insurance policy or health benefit arrangement whether or not subject to the state insurance laws, including coverage provided by a managed care organization or a fraternal benefit society.

(19) "Reinsurance premium" means the premium set by the board pursuant to section 41-5506, Idaho Code, to be paid by a reinsuring carrier for plans issued under the pool.

(20) "Reinsuring carrier" means a carrier participating in the individual high risk reinsurance pool established by this chapter.

(21) "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier to provide health care services to covered individuals.